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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0037085</u></p> <p>Facility Name: <u>LIBERTY HOUSE</u></p> <p>Address: <u>1304 WEST MACK AVE</u> <u>MARION</u> <u>62959</u> Number City Zip Code</p> <p>County: <u>WILLIAMSON</u></p> <p>Telephone Number: <u>6189979336</u> Fax # <u>6189935234</u></p> <p>IDPA ID Number: <u>37-1274937001</u></p> <p>Date of Initial License for Current Owners: <u>8/8/1992</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>STEPHEN BROWN</u> Telephone Number: <u>(618)997-9336</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1123 678 1260 824" rowspan="2"> Officer or Administrator of Provider </td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td data-bbox="1123 824 1260 889" rowspan="2"></td> <td>(Type or Print Name) <u>STEPHEN BROWN</u></td> </tr> <tr> <td>(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td data-bbox="1123 889 1260 1044" rowspan="4"> Paid Preparer </td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td data-bbox="1123 1044 1260 1122" rowspan="2"></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> <tr> <td> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>STEPHEN BROWN</u>	(Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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STATE OF ILLINOIS

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Facility Name & ID Number LIBERTY HOUSE# 0037085 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds16

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,824</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,824</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,637</u>			<u>5,637</u>	13
14	TOTALS	<u>5,637</u>			<u>5,637</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.79%

D. How many bed-hold days during this year were paid by Public Aid?

187

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location

Date started

11/8/1986

J. Was the facility purchased or leased after January 1, 1978?

YES ☒

Date

1/1/1991NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified

and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year

YES ☒NO ☐Tax Year: 12/31/2003Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis

STATE OF ILLINOIS

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Facility Name & ID Number LIBERTY HOUSE

0037085

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	17,350	3,114	600	21,064		21,064		21,064		1
2	Food Purchase		36,794		36,794		36,794		36,794		2
3	Housekeeping		4,622		4,622		4,622		4,622		3
4	Laundry		896		896		896		896		4
5	Heat and Other Utilities			10,916	10,916		10,916		10,916		5
6	Maintenance	3,443	7,671		11,114		11,114		11,114		6
7	Other (specify):*										7
8	TOTAL General Services	20,793	53,097	11,516	85,406		85,406		85,406		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	149,527	5,592	14,056	169,175		169,175		169,175		10
10a	Therapy			1,518	1,518		1,518		1,518		10a
11	Activities	18,333	4,800	1,160	24,293		24,293	(842)	23,451		11
12	Social Services										12
13	Nurse Aide Training										13
14	Program Transportation		1,896	1,886	3,782		3,782		3,782		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	167,860	12,288	19,820	199,968		199,968	(842)	199,126		16
	C. General Administration										
17	Administrative	40,000	1,467	6,000	47,467		47,467		47,467		17
18	Directors Fees										18
19	Professional Services			2,677	2,677		2,677	(1,729)	948		19
20	Dues, Fees, Subscriptions & Promotion			2,940	2,940		2,940	(503)	2,437		20
21	Clerical & General Office Expense			5,426	5,426		5,426		5,426		21
22	Employee Benefits & Payroll Tax			39,536	39,536		39,536		39,536		22
23	Inservice Training & Education			100	100		100		100		23
24	Travel and Seminar			160	160		160		160		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			2,907	2,907		2,907		2,907		26
27	Other (specify):*										27
28	TOTAL General Administration	40,000	1,467	59,746	101,213		101,213	(2,232)	98,981		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	228,653	66,852	91,082	386,587		386,587	(3,074)	383,513		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number **LIBERTY HOUSE**

#0037085

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			6,568	6,568		6,568	6,778	13,346			30
31	Amortization of Pre-Op. & Org											31
32	Interest			199				(398)	(199)			32
33	Real Estate Taxes			5,548	5,548		5,548		5,548			33
34	Rent-Facility & Grounds			72,000	72,000		72,000	(72,000)				34
35	Rent-Equipment & Vehicle											35
36	Other (specify): ^a			527				(527)				36
37	TOTAL Ownership			84,842	84,116		84,116	(66,147)	18,695			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:			1,075	1,075		1,075		1,075			41
42	Provider Participation Fee			33,052	33,052		33,052		33,052			42
43	Other (specify): ^a											43
44	TOTAL Special Cost Centers			34,127	34,127		34,127		34,127			44
45	GRAND TOTAL COST											
	(sum of lines 29, 37 & 44)	228,653	66,852	210,051	504,830		504,830	(69,221)	436,335			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(842)	V-11-2		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,386	V-30		9
10	Interest and Other Investment Income	(199)	V-32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(420)	V-C-20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer	(1,974)	V-19		22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona	(83)	V-20		25
26	Income Taxes and Illinois Persona				26
27	Property Replacement Tax	(527)	V-36		26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,659)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(65,005)	V30,32,34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (65,005)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (66,664)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			\$		38
39						39
40	Gift and Coffee Shop					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

LIBERTY HOUSEID# 0037085Report Period Beginning: 1/1/2003Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/2003

[illegible]

Summary B

12/31/2003

[illegible]

Facility Name & ID Number **LIBERTY HOUSE**# **0037085**Report Period Beginning: **1/1/2003** Ending: **12/31/2003**

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DON PIPPINS	66.667	KRYPTON	METROPOLIS	KEL-TECH MGMNT	ANNA	MANAGEMENT
		HOLLY HILL	ANNA	JR CENTER	ANNA	DAY TRAINING
		COLONIAL MANOR	ZEIGLER	ILS	ANNA	CILA
STEPHEN BROWN		NEW WAY	ANNA			
MARY ANN BROWN	16.633	COLONIAL MANOR	ZEIGLER			
	16700	COLONIAL MANOR	ZEIGLER			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	LEASE PAYMENTS	\$ 72,000	LIBERTY LAND TRUST NO.91	100.00%	\$	(72,000)	1
2	V	30	DEPRECIATION	6,750	LIBERTY LAND TRUST N O.91	100.00%	6,750	6,750	2
3	V		ACCOUNTING FEES	245			245	245	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 78,995			\$ 6,995	\$ * (65,005)	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number LIBERTY HOUSE# 0037085Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DON PIPPINS	OWNER/CONSULT	ADM.CONSULT	66.67	86,023	0.5	0.02	ADM.CONS.	\$ 6,000	17-3	1
2	STEPHEN BROWN	OWNER/RSD/ADM.	ADM./RSD	16.70		40	100.00	ADM./RSD	40,000	17-1	2
3	MARY ANN BROWN	OWNER/QMRP	QMRP	16.63		20	50.00	QMRP	20,000	1-Oct	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 66,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number LIBERTY HOUSE # 0037085 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
	A. Directly Facility Related										
	Long-Term										
1							\$	\$		\$	1
2											2
3											3
4											4
5											5
	Working Capital										
6											6
7											7
8											8
9	TOTAL Facility Related						\$	\$		\$	9
	B. Non-Facility Related*										
10											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related						\$	\$		\$	14
15	TOTALS (line 9+line14)						\$	\$		\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **LIBERTY HOUSE**# **0037085** Report Period Beginning: **1/1/2003** Ending: **12/31/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2002 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	\$	5,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	5,248	2
3. Under or (over) accrual (line 2 minus line 1).			\$	248	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	5,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	5,548	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1998 4,694	8	FOR OHF USE ONLY	
		1999 4,916	9	13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
		2000 5,616	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2001 5,048	11	15	LESS REFUND FROM LINE 6 \$ 15
		2002 5,298	12	16	AMOUNT TO USE FOR RATE CALCULATION\$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	LIBERTY HOUSE	COUNTY	WILLIAMSON
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FACILITY IDPH LICENSE NUMBER 0037085

CONTACT PERSON REGARDING THIS REPORT STEPHEN BROWN

TELEPHONE 6189979336 FAX #: 6189935234

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	06-13-126-010	AIKMAN,JM 4TH SOL	\$ 5,248.00	\$ 5,248.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 5,248.00	\$ 5,248.00

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number **LIBERTY HOUSE**# **0037085**

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

X. BUILDING AND GENERAL INFORMATION:A. Square Feet: **4,200** B. General Construction Type: Exterior **VENERR/SIDING** Frame **WOOD** Number of Stories **1**C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization ☐ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	HEALTHCARE	13,500	1985	\$ 12,000	1
2					2
3	TOTALS	13,500		\$ 12,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1986	1986	\$ 155,712	\$ 6,540	30	\$ 5,190	\$ (1,350)	\$ 113,807	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		BLDNG IMPROVEMENTS		1987	3,500	71	30	117	46	1,987	9
10		LANDSCAPING		1986	540		10			540	10
11		STORAGE BLDNG.		1988	595		30	20	20	399	11
12		DINING ROOM FLOOR		1988	1,379		30	46	46	1,038	12
13		CARPETS		1994	3,149	210	15		(210)	3,149	13
14		PAVED DRIVEWAY		1995	2,785	186	15	186		1,596	14
15		LANDSCAPING		1998	999	67	15	67		368	15
16		BATHROOM FLOORS		1999	428	38	7	61	23	275	16
17		NEW FLOOR		1990	4,384	139	40	110	(29)	1,443	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 173,471	\$ 7,251		\$ 5,797	\$ (1,454)	\$ 124,602	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 4,482	\$ 641	\$ 560	\$ (81)	7	\$ 1,338	71
72	Current Year Purchases	2,274		266	266	7	266	72
73	Fully Depreciated Assets	49,717		1,245	1,245	7	46,828	73
74								74
75	TOTALS	\$ 56,473	\$ 641	\$ 1,987	\$ 1,430		\$ 48,432	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PROGRAM TRANSP.	1993 FORD AEROSTAR	7/1/1994	\$ 19,759	\$	\$	\$	5	\$ 19,759	76
77	PROGRAM TRANSP.	1999 FORD VAN	5/10/1999	25,848	2,978	5,170	2,192	5	24,360	77
78	WHEEL CHAIR LIFT		7/1/1996	3,920	174	392	218	10	3,920	78
79										79
80	TOTALS			\$ 49,527	\$ 3,152	\$ 5,562	\$ 2,410		\$ 48,039	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 291,471	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,044	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 13,346	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,386	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 221,073	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column f

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1986	16	1/1/2000	\$ 72,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		16		\$ 72,000			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 1/1/2000

Ending 12/31/2005

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2004 \$ 72,000

13. 12/31/2005 \$ 72,000

14. 12/31/2006 \$ 72,000

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
<p>HAB AIDES WERE ALREADY CERTIFIED AND ON THE REGISTRY</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (c)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
(c) For in-house training programs only. Do not include fringe benefit.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities:

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,465	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	116,819		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	200		7
8	Accounts Receivable (owners or related parties)	44,500		8
9	Other(specify): EMP.INS.REC.	(189)		9
	TOTAL Current Assets			
10	(sum of lines 1 thru 9)	\$ 168,795	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	7,361		15
16	Equipment, at Historical Cost	93,575		16
17	Accumulated Depreciation (book methods)	(121,983)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp FURN.&FIXT.	27,236		22
23	Other(specify):			23
	TOTAL Long-Term Assets			
24	(sum of lines 11 thru 23)	\$ 6,189	\$	24
	TOTAL ASSETS			
25	(sum of lines 10 and 24)	\$ 174,984	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50		30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	1,388		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,300		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
	TOTAL Current Liabilities			
38	(sum of lines 26 thru 37)	\$ 6,738	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
	TOTAL Long-Term Liabilities			
45	(sum of lines 39 thru 44)	\$	\$	45
	TOTAL LIABILITIES			
46	(sum of lines 38 and 45)	\$ 6,738	\$	46
	TOTAL EQUITY(page 18, line 24)	\$ 163,498	\$	47
	TOTAL LIABILITIES AND EQUITY			
48	(sum of lines 46 and 47)	\$ 170,236	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 136,579	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 136,579	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	26,919	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 26,919	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 163,498	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number LIBERTY HOUSE

0037085

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 531,549	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 531,549	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	199	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 199	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 531,748	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	85,406	31
32	Health Care	199,968	32
33	General Administration	101,213	33
B. Capital Expense			
34	Ownership	84,116	34
C. Ancillary Expense			
35	Special Cost Centers	1,075	35
36	Provider Participation Fee	33,052	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 504,830	40
41	Income before Income Taxes (line 30 minus line 40)**	26,918	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 26,919	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **LIBERTY HOUSE**

0037085

Report Period Beginning: 1/1/2003

Ending:

12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,818	1,922	18,333	9.54	9
10	Activity Assistants					10
11	Social Service Worker					11
12	Dietician					12
13	Food Service Supervisor	1,920	2,024	17,200	8.50	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Worker	344	344	3,443	10.01	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,040	2,080	40,000	19.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,040	1,040	20,000	19.23	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	12,560	13,184	129,251	9.80	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,722	20,594	\$ 228,227 *	\$ 11.08	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	24	\$ 600		35
36	Medical Director	12	1,200		36
37	Medical Records Consultant				37
38	Nurse Consultant	391	9,769		38
39	Pharmacist Consultant	12	480		39
40	Physical Therapy Consultant	20	600		40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	32	918		43
44	Activity Consultant				44
45	Social Service Consultant	47	1,160		45
46	Other(specify) <u>PSYCHOLOGIST</u>	41	1,047		46
47	<u>AUDIOLOGIST</u>	21	640		47
48	<u>ADMINISTRATIVE</u>	24	6,000		48
49	TOTAL (lines 35 - 48)	624	\$ 22,414		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

A. Administrative Salaries:				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
STEPHEN BROWN	ADM/RSD	16.700	\$ 40,000	Workers' Compensation Insurance	\$ 5,890	IDPH License Fee	\$ 1,000		
				Unemployment Compensation Insurance	3,101	Advertising: Employee Recruitment			
				FICA Taxes	17,663	Health Care Worker Background Check			
				Employee Health Insurance	11,932	(Indicate # of checks performed _____)			
				Employee Meals		LIC.FEES	206		
				Illinois Municipal Retirement Fund (IMRF)*		IHCA ASSOC.DUES	936		
				EMPLOYEE XMAS BONUS	950	IHCA PAC DUES	(83)		
TOTAL (agree to Schedule V, line 17, col. 1)						MAGAZINE/NEWSPAPER	374		
(List each licensed administrator separately.)						CONTRIBUTIONS	(420)		
B. Administrative - Other						CABLE TV LEASE	(842)		
						Less: Public Relations Expense	()		
Description			Amount			Non-allowable advertising	()		
DON PIPPINS OWNER/ADM.CON.S.			\$ 6,000			Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3)									
(Attach a copy of any management service agreement)									
C. Professional Services				TOTAL (agree to Schedule V, line 22, col.8)					
Vendor/Payee	Type		Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
BARNETT & LEVINE	ACCOUNTANT		\$ 750	Description	Line #	Amount	Description	Amount	
F/M/G/R/	ATTORNEY		(1,974)			\$	Out-of-State Travel	\$	
							In-State Travel	260	
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)							(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$2500 attach copy of invoices.)							TOTAL	\$ 260	
			\$ (1,224)	TOTAL		\$			

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number LIBERTY HOUSE

STATE OF ILLINOIS

0037085

Report Period Beginning: 1/1/2003

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Ending: 12/31/2003

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union NO
- (2) Are there any dues to nursing home associations included on the cost report YES
If YES, give association name and amount ILLINOIS HEALTH CARE ASSOC.
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?
- (5) Have you properly capitalized all major repairs and equipment purchases YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 1,025 Line V-10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement NO
If YES, give effective date of lease
- (9) Are you presently operating under a sublease agreement YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over LIBERTY HOUSE 0030932 LIBERTY ENTERPRISES PARTNERSHIP 1/1/1991
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. 33,052
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? NO If YES, attach an explanation of the allocation
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V YES
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Indicate the amount \$
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel NO
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such program during this reporting period.
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period \$
- (17) Has an audit been performed by an independent certified public accounting firm? Firm Name: NO The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report N/A
Attach invoices and a summary of services for all architect and appraisal fees